Infant & Toddler Connection of Virginia – Individual Child Data Form

Child's Full Name: First, ______ M I, ______ Last Name

Street Address: ______

City, State Zip ______

Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Email: ______

Date of Birth: ___ ___/ ___ ___/ ___ ___ ___ ___

City/County of Residence: ______

Race Code: _____ **Gender:** ☐ Male ☐ Female

Service Coordinator: ______

Referral Source Code: ____ Other *(specify ______)*

Date of Referral: ___ ___/ ___ ___/ ___ ___ ___ ___

Intake Date: ___ ___/ ___ ___/ ___ ___ ___ ___

IFSP Date: ___ ___/ ___ ___/ ___ ___ ___ ___

Mitigating circumstances related to exceeding 45-day timeline

- ☐ Child ill
- ☐ Family ill
- ☐ Family scheduling preference
- ☐ Disaster/Severe Weather
- ☐ Provider unavailability
- ☐ Temporarily lost contact
- ☐ Foster/Surrogate Parent related issues

ITOTS Id: ______ **Local Case Number:** ______

(Mark the check box to the right of the parent's name below if their address is different from the child's address. Use the space below to record that parent's address.)

Parent Name: First, ______ M I, ______ Last Name ☐

Parent Name: First, ______ M I, ______ Last Name ☐

Street Address: ______

City, State Zip ______

Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Email: ______

Was Eligibility Determined?

☐ Yes ☐ No

Date Eligibility Determined: ___ ___/ ___ ___/ ___ ___ ___ ___

Result:

- ☐ Ineligible
- ☐ Eligible/Declined Services
- ☐ Eligible/Will Receive Services
- ☐ Eligible/Chose Other Services
- ☐ Eligible/Unable to Contact
- ☐ Eligible/Decline assessment for service planning
- ☐ Eligible/Ineligible at assessment for service planning
- ☐ Unable to Contact
- ☐ Deceased
- ☐ Declined Eligibility Determination
- ☐ Family Moved Before Eligibility

Exit Date: ___ ___/ ___ ___/ ___ ___ ___ ___

Race Codes:

A = Asian
B = Black/African American
H = Hispanic/Latino
P = Pacific Islander or Hawaiian Native
N = American Indian/Alaskan Native
W = White/Caucasian
T = Two or more races
U = Unknown

Referral Source Codes:

1. CSB
2. Local School
3. Health Department
4. DSS (Non-CAPTA)
5. Private, Non-profit Org
6. Hospital
7. Pediatrician/Family Physician Group/ Practice
8. Private Therapy
9. Friend/Neighbor/Relative
10. Parent/Guardian
11. DSS CAPTA
12. VISITS
13. Another System
14. Other

Primary Service Setting *(check only one)*

- ☐ 1. Program Designed for Children with Developmental Delays or Disabilities
- ☐ 2. Community-based setting for Typically Developing Children *(i.e. center or home-based childcare, preschool, library, park, grocery stores, etc.)*
- ☐ 3. Home
- ☐ 4. Hospital (inpatient)
- ☐ 5. Residential Facility
- ☐ 6. Service Provider Location *(center/clinic/hospital)*
- ☐ 7. Other *(specify ______)*

Medically Fragile

(Does this child meet the definition of medically fragile as defined in the instructions?)

☐ Yes ☐ No

Developmental Delay *(check all that apply)*

- ☐ Cognitive
- ☐ Physical: including fine & gross motor
- ☐ Communication
- ☐ Social or emotional
- ☐ Adaptive

Atypical Development *(check all that apply)*

- ☐ Atypical or questionable sensory-motor responses
- ☐ Atypical or questionable behaviors that interfere with acquisition of developmental skills
- ☐ Atypical or questionable social-emotional development
- ☐ Impairment in social interaction and communication skills along with restricted and repetitive behaviors

Diagnosed Disabling Condition *(check all that apply)*

- ☐ Autism Spectrum Disorder
- ☐ Brain or spinal cord trauma, with abnormal neurologic exam at discharge
- ☐ Cleft Lip and/or Palate
- ☐ Congenital or acquired hearing loss
- ☐ Chromosomal abnormalities
- ☐ Effects of toxic exposure including fetal alcohol syndrome, drug withdrawal, exposure to chronic maternal use of anticonvulsants, antineoplastics, and anticoagulants
- ☐ Endocrine Disorders
- ☐ Failure to thrive
- ☐ Gestational Age Less Than or Equal to 28 Weeks
- ☐ Hemoglobinopathies (Sickle Cell)
- ☐ Inborn errors of metabolism
- ☐ Meningomyelocele (spina bifida)
- ☐ Microcephaly
- ☐ NICU Stay of ≥28 Days
- ☐ Periventricular Leukomalacia
- ☐ Seizures with significant encephalopathy
- ☐ Severe attachment disorder
- ☐ Severe Grade 3 intraventricular hemorrhage with hydrocephalus or Grade 4 intraventricular hemorrhage
- ☐ Significant central nervous system anomaly *(e.g. cerebral palsy)*
- ☐ Symptomatic congenital infection
- ☐ Visual disabilities
- ☐ Other (*please specify ______*)

Family Survey Language:

- ☐ Arabic
- ☐ English
- ☐ Korean
- ☐ Urdu
- ☐ Mandarin
- ☐ Farsi
- ☐ Spanish
- ☐ Vietnamese

Child's Name: ____

Risk factors *(check all that apply)*

- ☐ Apgar Score of 0-3 at 5 minutes
- ☐ Birth Weight - Low (1500 g to <2500 g or 3.25lbs to 5.5 lbs)
- ☐ Birth Weight - Very Low (<1500 grams or <3.25 lbs.)
- ☐ Brain or spinal cord trauma
- ☐ Diagnosed genetic disorders
- ☐ Documented systemic infection, congenital or acquired

Environmental – social risk factor:

- ☐ Domestic violence
- ☐ Lack of adequate shelter
- ☐ Lack of familial support
- ☐ Family history of childhood Blindness
- ☐ Family history of childhood Deafness
- ☐ Founded child abuse/neglect
- ☐ Hyperbilirubinemia requiring exchange transfusion
- ☐ Lack of well-child care
- ☐ Lead poisoning
- ☐ Major congenital anomalies (see instructions)
- ☐ Maternal age 15 or less
- ☐ Maternal conditions during pregnancy such as accidents, phenylketonuria (PKU), maternal diabetes or sickle cell
- ☐ Meningitis
- ☐ Mother HIV Positive
- ☐ Neonatal Seizures
- ☐ Oxygen Therapy Greater than 28 days
- ☐ Persistent pulmonary hypertension
- ☐ Preemie – Gestational Age: 28-31 weeks
- ☐ Preemie – Gestational Age: 32-37 weeks
- ☐ Seizure disorder--excluding recurrent febrile seizures
- ☐ Severe chronic illness Severe parenting risk factor
- ☐ Mental illness
- ☐ Intellectual disability
- ☐ Physical disability
- ☐ Substance Abuse
- ☐ Small for gestational age (10th percentile or less)

Entitled Part C Service	Frequency				Intensity	Setting	*(Please also note "Other" service setting here)*	
	# of Times	Every/ only	Times During	Day/Week/ Month/Year	Minutes (5-360)		Provider	Local Provider

Entitled Part C Services

- Assistive Technology Services/ Devices
- Audiology
- Counseling Services
- Developmental Services
- Health Services
- Medical Services (diag/eval)
- Nursing Services
- Nutrition Services
- Occupational Therapy
- Physical Therapy
- Psychological Services
- Respite Care
- Service Coordination
- Sign/Cued Language
- Social Work Services
- Speech/Lang. Pathology
- Transportation
- Vision Services
- Other Entitled Part C Services
- *(Specify Other Entitled Part C Services Above)*

Service Settings

1. Program Designed for Children with Developmental Delays or Disabilities
2. Community-based setting for Typically Developing Children *(i.e. center or home-based childcare, preschool, library, park, grocery store, etc.)*
3. Home
4. Hospital (inpatient)
5. Residential Facility
6. Service Provider Location *(center/clinic/hospital)*
7. Other *(Specify other service setting in row above)*

Service Provider Codes:

1. Community Services Board
2. Local Education Agency
3. Department of Health
4. Department of Social Services
5. Department for the Blind and Visually Impaired
6. Department for the Deaf and Hard of Hearing
7. Extension Agency
8. Va. School for the Deaf and Blind
9. Private, Non-profit Organization
10. Hospital
11. Child Care Center and Organization
12. Pediatrician/Family Physician
13. Private Therapy Group/Practice
14. Other Service Provider *(Specify)*

Date Of Closure: ___ ___/ ___ ___/ ___ ___ ___ ___

Transition Destination: *(select one only)*

- ☐ Another Part C System in Virginia *(Specify:______________________________)*
- ☐ Deceased
- ☐ Exit At Age 3 – No referrals
- ☐ Exit with Referrals
  - ___ Preschool/Day Care
  - ___ Headstart
  - ___ Private Therapy
- ☐ IFSP Complete *(Child < 3)*
- ☐ Left Virginia
- ☐ Lost Contact With Family
- ☐ Other *(Specify:______________________)*
- ☐ Parent Withdrew
- ☐ Public School/Part B Eligible
- ☐ Part B Referral, Eligibility Not Yet Determined

Third Party Health Coverage *(Check all that apply)*

- ☐ Family Fees
- ☐ Medicaid/FAMIS ID#: _______________________
- ☐ None
- ☐ Insurance ID#: _______________________

Insurance Policy Name: _______________________

- ☐ TRICARE ID#: _______________________

Indicator Assessment	Entry	Interim 1			Interim 2			Exit			Missing Exit Data Justification
Assessment Date			Yes	No		Yes	No		Yes	No	
Positive Social Relationship											
Using Knowledge & Skills											
Takes Action to Meet Needs											

Missing Exit Data Justification: 1. Exited without sufficient notice // 2. Unable to Schedule – child ill // 3. Unable to Schedule – family scheduling // 4. Unable to Schedule – provider unavailability // 5. Other (*Specify:*____)